BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: JOEL ADAMS SMITHERS, D.O.
(a.k.a. Joel Alan Smithers)
License Number: 0102-204264
Case Numbers: 180977; 182379; 182868; 183963

ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met on May 10, 2018. The purpose of the meeting was to receive and act upon information indicating that Joel Adams Smithers, D.O., may have violated certain laws relating to the practice of osteopathic medicine in the Commonwealth of Virginia, as more fully set forth in the attached "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the license of Dr. Smithers, D.O., to practice osteopathic medicine in the Commonwealth of Virginia is SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

This Order shall be applicable to Dr. Smithers's multistate licensure privilege, if any, to practice osteopathic medicine in the Commonwealth of Virginia.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

FOR Jennifer L. Deal

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 5/10/18

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STATEMENT OF ALLEGATIONS

The Board alleges that:

1. At all times relevant hereto, Joel Adams Smithers, D.O., was licensed to practice osteopathic medicine in the Commonwealth of Virginia.

2. Joel Adams Smithers, D.O., violated Virginia Code § 54.1-2915(A)(8), (10), (13), (17), and (18) in that:

a. On March 7, 2017, Drug Enforcement Agency ("DEA") agents executed a search warrant on Dr. Smithers's personal vehicle parked at Smithers Community Health Care, the practice he owns, and at which he practiced from approximately September 2015 to August 2017. Pursuant to the search warrant, the agents found controlled and non-controlled substances packaged in empty vitamin bottles (as detailed in the table below), inside a black backpack, and $29,532.00 in cash in the vehicle's glove box.

Hylands Nerve Tonic #1	• 2 hydrocodone 10/325 • 15 hydromorphone 2mg • 12 half-pills hydromorphone 2mg • 4 small pieces hydromorphone 2mg • 1 Methadone 10mg • 8 hydromorphone 4mg • 28 Tramadol 50mg
Hylands Nerve Tonic #2	• 19 OxyContin 30mg • 8 Tramadol 50mg
Nature's Way MEGA-DHA Premium Fish Oil	• 40 oxymorphone 10mg (divided into 4 small baggies with 10 tablets each) • 69 oxymorphone HCL ER 5mg • 53 hydromorphone 4mg • 10 hydromorphone HCL 4mg • 156 Opana ER 5mg • 40 Opana ER 10mg • 6 Opana ER 20mg

	• 23 Morphine 30mg • 79 Morphine 15mg • 9 oxymorphone HCL XR 10mg • 5 alprazolam 1mg • 4 half-pills alprazolam 1mg • 60 Clonazepam .5mg • 56 Tramadol 50mg
Tylenol Extra Strength	• 33 oxymorphone HCL 10mg • 110 alprazolam 1mg • 1 half-pill alprazolam 1mg
Altoids tin	• 15 miscellaneous tablets, all non-controlled substances
Neck chain with hollow bullet pendent	• Broken pieces Dr. Smithers stated were Xanax

b. As a result of the search, Dr. Smithers was arrested in August 2017, and charged with possession of Schedule II controlled substances with the intent to distribute. His criminal trial is scheduled for October 29, 2018, through November 21, 2018, in the U.S. District Court for the Western District of Virginia.

c. Dr. Smithers explained that the medications were surrendered to him by patients at his medical practice in West Virginia. Further, he stated that he accepted surrendered medications from patients until he learned this practice was improper, and has since adopted a policy of a staff member supervising while patients flush unused medications in a toilet at his office.

3. Dr. Smithers violated §§ 54.1-2915(A)(3), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A), and 18 VAC 85-20-26(C) in his care and treatment of Patients A – F for chronic pain from September 2015 to August 2017. Specifically:

a. For all six patients, Dr. Smithers failed to perform and document physical examinations prior to initiating treatment with opioids for chronic pain, and failed to perform follow-up physical examinations, or document having performed such examinations.

b. Dr. Smithers failed to establish and maintain a treatment plan for Patients A, B. C, D, and F. At each patient's first office visit, Dr. Smithers filled in a form titled "Initial Pain Asssessment Tool", leaving many subsections of the form blank, including the subsection titled "Plan".

c. Dr. Smithers established a treatment plan for Patient E for treatment of his chronic pain, but the plan was not reflective of the treatment rendered. Specifically:

i. Although the treatment plan for Patient E did not include prescribing opioids, Dr. Smithers immediately began treating Patient E's neck, back, wrist, and leg pain with oxycodone and oxymorphone.

ii. Despite Patient E reporting that he had not previously tried any interventional treatments, Patient E's treatment plan does not include the use of, or referral for, any interventional treatments for his pain.

d. Dr. Smithers failed to consistently order and utilize urine drug screens ("UDSs") in his treatment of Patients A – F. Specifically:

i. Dr. Smithers failed to order a UDS for Patients A, B, C, E, and F, and review the results, prior to beginning treatment with opioids for the patients' chronic pain.

ii. Although Dr. Smithers ordered a UDS for Patient D on his first visit, without checking the results he prescribed Oxycodone 20 mg #150, oxymorphone 40mg #90, and alprazolam 1mg #30 to Patient D at his first visit.

iii. For Patients A – F, Dr. Smithers failed to review the results of the UDS that he ordered in a timely manner, and he continued to prescribe opioids to patients when he knew, or should have known, they were not compliant with their medications. For example:

- Patient A's first UDS on December 22, 2015, was positive for Valium and gabapentin, medications he was not then prescribed, but

Dr. Smithers did not review the results of the UDS until May 19, 2016, and prescribed oxycodone and oxymorphone throughout the entire treatment period.

- Patient D had a UDS on August 4, 2016, that was positive for Morphine. Dr. Smithers did not check the results of this UDS until November 1, 2016, and continued to prescribe oxycodone and oxymorphone to Patient D, after he knew of the positive result.
- Patient F did not have a UDS until December 21, 2015, three months after Dr. Smithers began prescribing her morphine and hydromorphone. Dr. Smithers continued to prescribe morphine and hydromorphone even though he did not check Patient F's December 21, 2015 UDS results until May 26, 2016. The results showed Patient F was negative for all of her prescribed medications. Nevertheless, Dr. Smithers still prescribed oxymorphone and hydromorphone to Patient F in May, June, and July 2016.

e. Dr. Smithers failed to order updated diagnostic testing or imaging studies for Patients A – E, and prescribed opiates based on outdated or clinically insufficient diagnostic results. For example:

i. Dr. Smithers reviewed Patient A's 2007 lumbar spine MRI results, finding an "essentially negative study"; Patient A's 2010 thoracic spine x-ray, revealing no abnormalities; and Patient A's 2015 foot x-ray, showing no abnormality. Despite these findings, Dr. Smithers began prescribing oxycodone and oxymorphone to Patient A on his first visit.

ii. Patient E stated on his intake form dated September 16, 2015, that his pain initiated from a motor vehicle accident 15 years earlier, and that he has carpal tunnel and arthritis. Dr. Smithers reviewed Patient E's 2012 lumbar spine MRI and cervical spine MRI, showing mild lumbar spondylosis and a small central disk herniation, and mild left foraminal stenosis. Based on these findings only, Dr. Smithers prescribed oxycodone and oxymorphone to Patient E absent updated imaging studies.

4. Dr. Smithers violated §§ 54.1-2915(A)(3), (13), (16), and (17), 54.1-3303(A), and 54.1-3408(A) in his care and treatment of Patients A, B, C, D, and F for chronic back pain in that he failed to take appropriate action when patients exhibited drug-seeking behavior. Specifically:

a. Patient A had multiple inconsistent UDS results, for which Dr. Smithers took no action, and continued to prescribe opioids without change. For example:

i. Patient A's December 22, 2015, UDS was inconsistent in that it was positive for Fioricet and Phentermine, two medications that were not prescribed by Dr. Smithers, and that Patient A had not disclosed were being prescribed by another provider.

ii. Dr. Smithers was unaware of the above inconsistency until he reviewed the UDS results on May 19, 2016, and ordered another UDS. This second UDS was also positive for Fioricet and Phentermine. Patient A stated that he was not going back to the provider who prescribed those medications, and Dr. Smithers began prescribing Fioricet to Patient A without documenting the rationale for prescribing this medication, and without coordinating care with the original prescriber or Patient A's primary care provider.

iii. Patient A's September 15, 2016 UDS was positive for marijuana, and Dr. Smithers took no action other than to approve continuing Patient A's monitoring status as "high". Patient A's chart included a "Discharge and Titration" notice regarding this failure, but it was not signed by Patient A, only initialed by Dr. Smithers, and Patient A was not discharged from Dr. Smithers's care.

iv. Patient A again had an inconsistent UDS on November 15, 2016. The UDS was negative for oxycodone, prescribed by Dr. Smithers, and was inconsistent for alprazolam, prescribed by his primary care physician. Dr. Smithers took no action regarding these inconsistencies.

b. Patient B admitted to non-compliance with his medications, and had multiple inconsistent UDSs for which Dr. Smithers took no action. Specifically:

i. Patient B's first UDS on February 2, 2016, was positive for hydrocodone, a medication he was not prescribed. Dr. Smithers took no action, and continued prescribing Patient B oxycodone.

ii. Patient B admitted in April 2016 that he was noncompliant with his medications. He stated he ran out of his oxycodone early because he was taking more oxycodone than prescribed due to not being able to fill his Opana ER prescription. Dr. Smithers took no action and continued to prescribe the same medications to Patient B.

iii. Patient B's second UDS on May 26, 2016 was positive for Xanax, a medication that he was not prescribed. Patient B was placed on a "high risk contract" for monitoring, but Dr. Smithers continued to prescribe OxyContin and oxycodone without change.

iv. Dr. Smithers took no action, even though Patient B signed a "high risk contract" on July 28, 2016, when Patient B's August 22, 2016 UDS was negative for hydromorphone, a medication he was prescribed.

c. Dr. Smithers did not take responsive action or discharge Patient C until July 2016, despite multiple inconsistent UDS results, and other instances of drug-seeking behavior. Specifically:

i. Patient C had a UDS on May 20, 2015, ordered by his previous provider, that was positive for buprenorphine, which he was not prescribed. Dr. Smithers reviewed the May 20,

2015 UDS results at Patient C's first visit on October 5, 2015, did not order a new UDS, and began prescribing oxycodone to Patient C.

ii. Patient C filled a prescription for Percocet 5/325 #40 on May 19, 2016, which was written by another provider. Dr. Smithers did not check Patient C's prescription history from the Prescription Monitoring Program ("PMP") and was not aware that Patient C was receiving controlled substances from other providers. Dr. Smithers continued to write prescriptions for OxyContin and oxycodone for Patient C.

iii. On June 23, 2016, Patient C reported that he was without his prescribed medications because they were stolen from his mother's residence. There is no police report in Patient C's chart, and Dr. Smithers continued to prescribe opiates to Patient C.

iv. Also on June 23, 2016, Dr. Smithers reviewed the results of Patient C's May 26, 2016 UDS, which was again positive for buprenorphine. The UDS was negative for morphine and hydromorphone, which he was prescribed at that time. Patient C admitted to taking a piece of a Suboxone strip because he ran out of his prescribed medication.

d. Dr. Smithers failed to take appropriate action and continued to prescribe oxycodone and oxymorphone to Patient D until his dismissal despite repeated inconsistent UDS results. For example:

i. Patient D's August 4, 2016 UDS was positive for morphine, which Dr. Smithers did not prescribe. Patient D denied taking morphine, and Dr. Smithers continued to prescribe oxycodone and oxymorphone.

ii. Patient D's next UDS on November 1, 2016 was positive for Valium and marijuana. Patient D denied taking Valium and admitted using marijuana. Dr. Smithers took no action other than to approve moving Patient D to "high risk status" and signing a "high risk contract".

iii. Patient D's November 1, 2016 UDS was positive for his prescribed oxycodone and oxymorphone despite the fact that Patient D missed his October 2016 office visit, had not filled a prescription for October, and admitted he was out of his medications for over three weeks. Patient C admitted he used marijuana because he had run out his prescribed pain medication.

iv. Patient D's November 30, 2016 UDS was still positive for marijuana, and was negative for alprazolam, a medication he was prescribed. Dr. Smithers took no action, and continued to prescribe oxycodone and oxymorphone.

e. Dr. Smithers failed to properly monitor Patient F and was not aware of her drug seeking behavior for many months. Specifically:

i. Patient F's first UDS on December 21, 2015, was negative for all medications she was prescribed by Dr. Smithers. Dr. Smithers did not review the results of this UDS until May 26, 2016, and continued to prescribe morphine and hydromorphone, and later oxymorphone and hydromorphone.

ii. Patient F's second UDS on May 26, 2016, was negative for all prescribed medications, and positive for alprazolam, which she was not prescribed. Dr. Smithers did not review the results until June 22, 2016, and Dr. Smithers continued to prescribe hydromorphone and oxymorphone to Patient F.

iii. Patient F's July 26, 2016 UDS was again negative for all her prescribed medications.

5. Dr. Smithers violated § 54.1-2915(A)(4), (13), and (14) in that he is unable to practice osteopathic medicine with safety to patients, and represents a danger to patients and the public. Specifically:

a. In May 2013, Dr. Smithers resigned from his residency program at Blue Ridge Healthcare, Morganton, North Carolina, after he was suspended with pay for lying to a police officer during a traffic stop. Specifically, Dr. Smithers told the officer that he was on his way to the hospital, in an attempt to avoid a charge for driving while intoxicated. The officer alerted the hospital that Dr. Smithers was on his way, but had an odor of alcohol on his breath. As a result of his resignation from the residency program, Dr. Smithers signed a two-year monitoring contract with the North Carolina Physicians Health Program ("NCPHP") in July 2014.

i. – vi. See Confidential Exhibit

b. Upon licensure by the Virginia Board of Medicine, Dr. Smithers entered the Virginia Health Practitioners' Monitoring Program ("HPMP") on August 12, 2015, admitting that his mental illness may impair his ability to practice.

c. On November 30, 2015, Dr. Smithers was dismissed from HPMP for returning to practice in Virginia prior to receiving permission to do so. Specifically:

i. Dr. Smithers submitted a description of the practice he wished to open to HPMP on November 18, 2015. While reviewing this information, HPMP discovered that Dr. Smithers had already opened his practice, and had been seeing patients as well as writing prescriptions for Schedule II controlled substances.

ii. Dr. Smithers admitted to opening his practice in September 2015, believing erroneously that he did not require permission from HPMP to begin practicing in Virginia. Dr. Smithers stated that he merely thought he was required to keep HPMP informed about his practice, despite both his Participation Contract and Recovery Monitoring Contract indicating he required HPMP's approval to begin treating patients.

d. Dr. Smithers re-entered HPMP on January 19, 2016, and signed a Recovery Monitoring Contract on February 29, 2016. Dr. Smithers was approved to return to practice in May 2016 with a work-site monitor and a peer monitor reporting to HPMP each month.

e. Dr. Smithers was again dismissed from HPMP on November 1, 2017, due to noncompliance with his Recovery Monitoring Contract. Specifically:

i. Dr. Smithers peer monitor reported to HPMP in August 2017 that Dr. Smithers was arrested for federal drug possession charges, information Dr. Smithers had not reported to the HPMP. As a result, Dr. Smithers was placed on predismissal status, required to refrain from practice, required to complete a fitness-for-duty assessment at Vanderbilt University, take a continuing education course on boundaries at the Center for Personalized Education for Physicians ("CPEP"), and take a prescribing course at Case Western University.

ii. In September 2017, HPMP received notification that Dr. Smithers entered into a Consent Order with the West Virginia Board of Osteopathic Medicine ("West Virginia Board"), information that Dr. Smithers had not reported to HPMP.

iii. Dr. Smithers failed to attend his fitness-for-duty assessment at Vanderbilt University, scheduled for September 25, 2017.

iii. Dr. Smithers failed urine drugs screens on September 29, October 13, and October 20, 2017, all of which tested positive for alcohol metabolites. A PEth test from October 27, 2017, was also positive for alcohol metabolites. After October 27, 2017, Dr. Smithers stopped calling the test line, and had no further contact with HPMP.

iv. Dr. Smithers never participated in CPEP, and despite rescheduling his fitness-for-duty assessment for November 2017, he never attended.

f. Dr. Smithers's diagnoses of major depressive disorder, generalized anxiety disorder, and ADHD require treatment and ongoing monitoring.

6. Dr. Smithers violated § 54.1-2915(A)(5) in that, by Consent Order entered September 1, 2017, the West Virginia Board imposed a $1,000.00 fine and ordered him to complete continuing educations courses about HIPAA and prescribing practices for controlled substances. This action was based on findings that during a search of Dr. Smithers's practice, the West Virginia Office of Health Facility Licensure and Certification ("OHFLAC") found urine-specimen bags containing confidential patient information, with Dr. Smithers's name attached to the bags, in a dumpster behind the practice. The previous day, Dr. Smithers had refused the OHFLAC search, and when OHFLAC team returned the following day with an inspection warrant they were informed by a maintenance employee that staff from Dr. Smithers's practice had placed items in the dumpster.

Pursuant to Virginia Code § 54.1-2400.2(K), the Board considered whether to disclose or not disclose Dr. Smithers's health records or health services.

See Confidential Attachment for the names of the patients referenced above.

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

5/10/18
Date